PATIENT REGISTRATION

DATE:_______________

Name:_____________________________ Mar. Status: S M W D Sep DOB:_________________
Billing Address:_____________________________ City, State, Zip:_____________________
Home Phone:____________ Work Phone:____________ Occup./Employer;___________________
Employer Phone: _________________
Spouse's Name:_________________________ DOB:______ Occup./Employer:_________________
Employer hone:________________

If Under 18 Parent/Guardian____
Emergency Contact(Other than spouse)______________________________ Phone:______________
Address:_______________________________________ Relation:_____________________

Patient S.S.#________________ Driver's License#__________ Referred By:_________________

INSURANCE AND BILLING INFORMATION

Billing name(If other than patient)___________________________ Relationship________________
Billing Address:____ Phone#____________________

PAYMENT REQUIRED AT TIME OF SERVICE-UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1. Insurance Company:____________________________________ Effective date:_____________
Address:____
Subscriber's Name:______________________ ID:#_______________ Group#_______________

2. Insurance Company:____________________________________ Effective date:_____________
Address:_____________________________________
Subscriber's Name:______________________ ID:#_______________ Group#_______________

Medicare #:______________________________ Medicaid I.D.#____________________________
Other Coverage:____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. ________________
for services rendered by him in person or under his/her supervision. I understand that
I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. __________________ to release my medical or incidental information
that may be necessary for either medical care or processing applications for financial benefits.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release
of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT (please print)____ Date:_______________
PARENT/GUARDIAN (please print)______________________________
SIGNATURE:____